BLOOMFIELD
DENTAL CARE

## Patient Information

Date:_____

Name _____ Soc. Sec. _____

Address _____ Birth Date _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation:_____ e-mail address _____

Check Appropriate Box Minor ☐ Single ☐ Married ☐

Spouse's Name _____

Dependents _____

Date of your last dental cleaning _____

Whom may we thank for referring you? _____

## Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Social Security _____ Birth Date _____

Name of Employer _____

Employer Address _____ City _____ State _____

Dental Insurance _____ Group # _____

## Secondary Dental Insurance Information

Name of Insured _____ Relationship to patient _____

Social Security Number _____ Birth Date _____

Name of Employer _____

Address of Employer _____ City _____ State _____

Dental Insurance Company _____ Group Number _____

(OVER)

# Medical History

*Do you have or have you had any of the following—indicate with an (x)*

- ☐ ***Drug allergies—list below****
- ☐ *Allergy to Anesthetics*
- ☐ *Allergy to Latex*
- ☐ *Any Heart Ailments*
- ☐ *High Blood Pressure*
- ☐ *Pacemaker*
- ☐ *Taking blood thinners*
- ☐ *Taking Fosamax, Actonel or Boniva (Bisphosphonates)*
- ☐ *Anemia or blood problems*
- ☐ *Excess bleeding from cuts*
- ☐ *Ulcer or Colitis*
- ☐ *Hip/Knee replacement*
- ☐ *Pins/plates/rod placement*
- ☐ *Liver problems/Hepatitis*
- ☐ *Kidney problems*
- ☐ *Diabetes*
- ☐ *Malignancies*
- ☐ *Radiation treatments*
- ☐ *Stroke/T.I.A.*
- ☐ *Psychiatric care or Emotional problems*
- ☐ *Neurological problems*
- ☐ *Eye Disorders*
- ☐ *Tuberculosis*
- ☐ *Respiratory problems*
- ☐ *Smoking: How much per day?____*
- ☐ *Alcohol: How much/often? _____*
- ☐ *Sinus problems*
- ☐ *Hay Fever or Allergies*
- ☐ *Asthma*
- ☐ *Tonsillitis, currently*
- ☐ *Arthritis*
- ☐ *Thyroid problems*
- ☐ *Currently Pregnant, if so what month?*
- ☐ *Auto Immune deficiencies*
- ☐ *HIV/AIDS*
- ☐ *Epilepsy*

*Other:* _____

- ☐ *Had Medical Exam within the last year?*

**List Drug Allergies:* _____

*List all medications you are currently taking:* _____

Name of Physician: _____

Initial & Date _____

Initial & Date _____

# Dental History

| | Yes | No |
|---|---|---|
| Do your gums bleed while brushing or flossing? | ❑ | ❑ |
| Are your teeth sensitive to hot or cold liquids/foods? | ❑ | ❑ |
| Are your teeth sensitive to sweet or sour liquids/foods? | ❑ | ❑ |
| Do you feel pain in any of your teeth? | ❑ | ❑ |
| Do you have any sores or lumps in or near your mouth? | ❑ | ❑ |
| Have you had any head, neck or jaw injuries? | ❑ | ❑ |
| Have you ever experienced any of the following problems in your jaw? | ❑ | ❑ |
| Clicking | ❑ | ❑ |
| Pain (joint, ear, side of face) | ❑ | ❑ |
| Difficulty in opening or closing | ❑ | ❑ |
| Difficulty in chewing | ❑ | ❑ |
| Do you have frequent headaches? | ❑ | ❑ |
| Do you clench or grind your teeth? | ❑ | ❑ |
| Do you bite your lips or cheeks frequently? | ❑ | ❑ |
| Have you ever had any difficult extractions in the past? | ❑ | ❑ |
| Have you ever had any prolonged bleeding following extractions? | ❑ | ❑ |
| Have you had any orthodontic treatment? | ❑ | ❑ |
| Do you wear dentures or partials? Date of placement _____ | ❑ | ❑ |
| Do you use any tobacco products? | ❑ | ❑ |
| **Are you satisfied with the color of your teeth?** | ❑ | ❑ |
| **Do you like your smile?** | ❑ | ❑ |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date: _____

Signature of patient (or parent, if minor)